		FOR OHF USE					

LLT

2000

STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

I. IDPH Facility ID Number: 0021832

Facility Name: Arthur Merkle Clara Knipprath Nursing Home

Address: 1190 East 2900 North Road (Number) Clifton (City) 60927 (Zip Code)

County: Iroquois

Telephone Number: (815) 694-2306 **Fax #** (815) 694-2818

IDPA ID Number: 36-284135801

Date of Initial License for Current Owners: 10/15/75

Type of Ownership:

x	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL		
	x	Charitable Corp.		Individual		State	
		Trust		Partnership		County	
IRS Exemption Code	501(c)(3)			Corporation		Other	
				"Sub-S" Corp.			
				Limited Liability Co.			
				Trust			
				Other			

In the event there are further questions about this report, please contact:
Name: Brother Damien **Telephone Number:** (815) 694-2306

II. CERTIFICATIO

I have examine
State of Illinois, fc
and certify to the
are true, accurate
applicable instruc
is based on all inf

Intentional mis
in this cost report

Officer or Administrator of Provider	(Signed) (Type or (Title)
Paid Preparer	(Signed) (Print Na and Title) (Firm Na & Addres (Telephor

DPA 3745 (N-4-99)

IMPORTANT NOTICE

THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

N BY AUTHORIZED FACILITY OFFICER

ed the contents of the accompanying report to the
or the period from 1/1/2000 to 12/31/2000
best of my knowledge and belief that the said contents
and complete statements in accordance with
tions. Declaration of preparer (other than provider)
ormation of which preparer has any knowledge.

representation or falsification of any information
may be punishable by fine and/or imprisonment.

(Date)

Print Name) Brother Damien, OSF

Executive Director

See Accountant's report

(Date)

ume

) Mark L Smith

Bacon Smith Koelling & Ohm, PC

me 200 East Court Street, Suite 600

ss) Kankakee, IL 60901

ne) (815) 937-1997 Fax # (815) 935-0360

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

ORT

IL478-2471

STATE OF ILLINOIS

Facility Name & ID Number Arthur Merkle Clara Knipprath Nursing Home # 0021832

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	99	Skilled (SNF)	99	36,234	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	99	TOTALS	99	36,234	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	321	456		777	8
9	SNF/PED					9
10	ICF	12,072	17,367		29,439	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	12,393	17,823		30,216	14

D. How many l
0

E. List all servi
(E.g., day car
Meals on Whee

F. Does the fac

G. Do pages 3 &
investments
YES

H. Does the BA
YES

I. On what dat
Date started

J. Was the faci
YES

K. Was the fac
YES
of beds certi

Medicare Inter

IV. ACCOUNT

ACCRUAL

Is your fiscal

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) **83.39%**

Tax Year:
*** All facilities c**
SEE ACCOUNTANTS' COMPILATION RE

Print Preview

Report Period Beginning: 1/1/2000 Ending: 12/31/2000

bed-hold days during this year were paid by Public Aid?
_____ (Do not include bed-hold days in Section B.)

ices provided by your facility for non-patients.
re, "meals on wheels", outpatient therapy)
els

ility maintain a daily midnight census? Yes

& 4 include expenses for services or
not directly related to patient care?
[x] NO [ ]

ALANCE SHEET (page 17) reflect any non-care assets?
[x] NO [ ]

e did you start providing long term care at this location?
10/6/75

lity purchased or leased after January 1, 1978?
[ ] Date _____ NO [x]

ility certified for Medicare during the reporting year?
[ ] NO [x] If YES, enter number
fied _____ and days of care provided _____

rmediary

TING BASIS

	MODIFIED CASH*		CASH*
[x]		[ ]	[ ]

year identical to your tax year? YES [x] NO [ ]

12/31/2000 **Fiscal Year:** 12/31/2000

other than governmental must report on the accrual basis.

EPORT

IF AN ERROR OCCURS IN LINE 8, 16 OR 28, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

STATE OF ILLINOIS

Facility Name & ID Number Arthur Merkle Clara Knipprath Nursing Hon # 0021832 **Report Period**

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

		Costs Per General Ledger				Reclass-	Reclassified
	Operating Expenses	Salary/Wage	Supplies	Other	Total	ification	Total
	A. General Services	1	2	3	4	5	6
1	Dietary	237,565	20,187	12,222	269,974		269,974
2	Food Purchase		157,480		157,480	(20,480)	137,000
3	Housekeeping	69,585	293	11,379	81,257		81,257
4	Laundry	24,884	4,337	9,564	38,785		38,785
5	Heat and Other Utilities			126,533	126,533	(2,067)	124,466
6	Maintenance	68,043	3,020	7,512	78,575		78,575
7	Other (specify):* ILU			1,155	1,155		1,155
8	**TOTAL General Services**	400,077	185,317	168,365	753,759	(22,547)	731,212
	B. Health Care and Programs						
9	Medical Director			2,600	2,600		2,600
10	Nursing and Medical Records	838,244	82,106	3,732	924,082		924,082
10a	Therapy	13,331		1,274	14,605		14,605
11	Activities	52,289	8,315	7,436	68,040		68,040
12	Social Services	13,093			13,093		13,093
13	Nurse Aide Training						
14	Program Transportation			446	446		446
15	Other (specify):* Sundries			762	762		762
16	**TOTAL Health Care and Programs**	916,957	90,421	16,250	1,023,628		1,023,628
	C. General Administration						
17	Administrative	75,000			75,000	5,322	80,322
18	Directors Fees						
19	Professional Services			18,120	18,120		18,120
20	Dues, Fees, Subscriptions & Promotions			4,122	4,122		4,122
21	Clerical & General Office Expenses	76,578	4,508	6,466	87,552		87,552
22	Employee Benefits & Payroll Taxes			305,394	305,394	20,480	325,874
23	Inservice Training & Education			1,384	1,384		1,384
24	Travel and Seminar			220	220		220
25	Other Admin. Staff Transportation			926	926		926
26	Insurance-Prop.Liab.Malpractice			20,928	20,928	(157)	20,771
27	Other (specify):*			22,370	22,370		22,370
28	**TOTAL General Administration**	151,578	4,508	379,930	536,016	25,645	561,661
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,468,612	280,246	564,545	2,313,403	3,098	2,316,501

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000. SEE ACCOUNT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of e

Print Preview

l **Beginning:** **1/1/2000** **Ending:** **12/31/2000**

Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
0	269,974			1
(12,250)	124,750			2
(17,774)	63,483			3
0	38,785			4
(22,902)	101,564			5
(11,791)	66,784			6
(1,155)				7
(65,872)	665,340			8
0	2,600			9
(13,000)	911,082			10
0	14,605			10a
(3,488)	64,552			11
0	13,093			12
0				13
0	446			14
(762)				15
(17,250)	1,006,378			16
(20,322)	60,000			17
0				18
0	18,120			19
0	4,122			20
(302)	87,250			21
(4,942)	320,932			22
0	1,384			23
0	220			24
0	926			25
(1,795)	18,976			26
(22,370)				27
(49,731)	511,930			28
(132,853)	2,183,648			29

'ANTS' COMPILATION REPORT
ach reclassification.

IF AN ERROR OCCURS IN LINE 37 OR 44, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

STATE OF ILLINOIS

Facility Name & ID Number Arthur Merkle Clara Knipprath Nursing Hor **#** 0021832 **Report Period**

V. COST CENTER EXPENSES (continued)

		Cost Per General Ledger				Reclass-	Reclassified
	Capital Expense	Salary/Wage	Supplies	Other	Total	ification	Total
	D. Ownership	1	2	3	4	5	6
30	Depreciation			205,173	205,173	(3,098)	202,075
31	Amortization of Pre-Op. & Org.						
32	Interest						
33	Real Estate Taxes						
34	Rent-Facility & Grounds						
35	Rent-Equipment & Vehicles						
36	Other (specify):*						
37	**TOTAL Ownership**			205,173	205,173	(3,098)	202,075
	Ancillary Expense						
	E. Special Cost Centers						
38	Medically Necessary Transportation						
39	Ancillary Service Centers						
40	Barber and Beauty Shops		4	19,183	19,187		19,187
41	Coffee and Gift Shops						
42	Provider Participation Fee			54,352	54,352		54,352
43	Other (specify):*						
44	**TOTAL Special Cost Centers**		4	73,535	73,539		73,539
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,468,612	280,250	843,253	2,592,115	0	2,592,115

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Print Preview

Print Preview

SEE ACCOUNTANTS' COMPILATION REPORT

l Beginning: 1/1/2000 Ending: 12/31/2000

Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
(81,441)	120,634			30
0				31
0				32
0				33
0				34
0				35
0				36
(81,441)	120,634			37
0				38
0				39
(19,187)				40
0				41
0	54,352			42
0				43
(19,187)	54,352			44
(233,481)	2,358,634			45

FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

STATE OF IL

Facility Name & ID Number Arthur Merkle Clara Knipprath Nursing Home # 0021832 Report P

VI. ADJUSTMENT DETAIL A. The expenses indicated below are non-allowable and should be adjusted out of Sche
In column 2 below, reference the line on which the particular cost was included. (Se

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY		
1	Day Care	$		$	1	
2	Other Care for Outpatients				2	
3	Governmental Sponsored Special Programs				3	31
4	Non-Patient Meals	(6,295)	2		4	32
5	Telephone, TV & Radio in Resident Rooms	(3,488)	11		5	
6	Rented Facility Space				6	33
7	Sale of Supplies to Non-Patients				7	
8	Laundry for Non-Patients				8	34
9	Non-Straightline Depreciation	6,503	30		9	35
10	Interest and Other Investment Income				10	36
11	Discounts, Allowances, Rebates & Refunds				11	
12	Non-Working Officer's or Owner's Salary				12	37
13	Sales Tax				13	
14	Non-Care Related Interest				14	
15	Non-Care Related Owner's Transactions				15	
16	Personal Expenses (Including Transportation)				16	
17	Non-Care Related Fees				17	
18	Fines and Penalties				18	
19	Entertainment				19	
20	Contributions				20	
21	Owner or Key-Man Insurance				21	
22	Special Legal Fees & Legal Retainers				22	
23	Malpractice Insurance for Individuals				23	38
24	Bad Debt	(22,370)	27		24	39
25	Fund Raising, Advertising and Promotional				25	40
26	Income Taxes and Illinois Personal Property Replacement Tax				26	41 42
27	Nurse Aide Training for Non-Employees				27	43
28	Yellow Page Advertising				28	44
29	Other-Attach Schedule	(207,831)			29	45
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (233,481)		$	30	46

B. If
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C. An
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refe
(Se

47

OHF USE ONLY									
48		49		50		51		52	

SEE ACCOUN

Print Preview

eriod Beginning: 1/1/2000 Ending: 12/31/2000

dule V, pages 3 or 4 via column 7.
e instructions.)

there are expenses experienced by the facility which do not appear in the neral ledger, they should be entered below.(See instructions.)

	1 Amount	2 Reference	
Non-Paid Workers-Attach Schedule*	$		31
Donated Goods-Attach Schedule*			32
Amortization of Organization & Pre-Operating Expense			33
Adjustments for Related Organization Costs (Schedule VII)			34
Other- Attach Schedule			35
SUBTOTAL (B): (sum of lines 31-35)	$		36
TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))	$ (233,481)		37

ese costs are only allowable if they are necessary to meet minimum nsing standards. Attach a schedule detailing the items included these lines.

re the following expenses included in Sections A to D of pages 3 l 4? If so, they should be reclassified into Section E. Please erence the line on which they appear before reclassification.
e instructions.)

	1 Yes	2 No	3 Amount	4 Reference	
Medically Necessary Transport.			$		38
					39
Gift and Coffee Shops					40
Barber and Beauty Shops					41
Laboratory and Radiology					42
Prescription Drugs					43
Exceptional Care Program					44
Other-Attach Schedule					45
Other-Attach Schedule					46

TOTAL (C): (sum of lines 38-46)	**$**		**47**

NTANTS' COMPILATION REPORT

Detail lines 29 and 35 of Page 5 starting in B44. **DO NOT DRAG AND DROP CELLS.**

The amounts in column F will transfer to the Adj. Summary column automatically.
The amounts in the Adj. Summary column are linked to pages Summary A and B.

To Print the Other Adjustments you have
1. **Highlight the other adjustr starting at B44 and continu Be sure the columns highli**
2. **Push the Print Other Adju button.**

STATE OF ILLINOIS **Page 5A**

Facility Name **Arthur Merkle Clara Knipprath Nursing Home**

ID# **0021832**

Report Period Beginning: **1/1/2000**

Ending: **12/31/2000**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	Sch V	Adj. Summary
The information listed in B13 thru G43 is from Page 5.					
1	**Day Care**	0	0	**Line 1**	0
2	**Other Care for Outpatients**	0	0	**Line 2**	(12,250)
3	**Governmental Sponsored Special Programs**	0	0	**Line 3**	(17,774)
4	**Non-Patient Meals**	(6,295)	2	**Line 4**	0
5	**Telephone, TV & Radio in Resident Rooms**	(3,488)	11	**Line 5**	(22,902)
6	**Rented Facility Space**	0	0	**Line 6**	(11,791)
7	**Sale of Supplies to Non-Patients**	0	0	**Line 7**	(1,155)
8	**Laundry for Non-Patients**	0	0	**Line 8**	(65,872)
9	**Non-Straightline Depreciation**	6,503	30	**Line 9**	0
10	**Interest and Other Investment Income**	0	0	**Line 10**	(13,000)
11	**Discounts, Allowances, Rebates & Refunds**	0	0	**Line 10a**	0
12	**Non-Working Officer's or Owner's Salary**	0	0	**Line 11**	(3,488)
13	**Sales Tax**	0	0	**Line 12**	0
14	**Non-Care Related Interest**	0	0	**Line 13**	0
15	**Non-Care Related Owner's Transactions**	0	0	**Line 14**	0
16	**Personal Expenses (Including Transportation)**	0	0	**Line 15**	(762)
17	**Non-Care Related Fees**	0	0	**Line 16**	(17,250)
18	**Fines and Penalties**	0	0	**Line 17**	(20,322)
19	**Entertainment**	0	0	**Line 18**	0
20	**Contributions**	0	0	**Line 19**	0
21	**Owner or Key-Man Insurance**	0	0	**Line 20**	0
22	**Special Legal Fees & Legal Retainers**	0	0	**Line 21**	(302)

Print Other Adjustm

23	**Malpractice Insurance for Individuals**	0	0	**Line 22**	(4,942)
24	**Bad Debt**	(22,370)	27	**Line 23**	0
25	**Fund Raising, Advertising and Promotional**	0	0	**Line 24**	0
26	**Income & IL Personal Property ReplacementTaxes**	0	0	**Line 25**	0
27	**Nurse Aide Training for Non-Employees**	0	0	**Line 26**	(1,795)
28	**Yellow Page Advertising**	0	0	**Line 27**	(22,370)
29	**Non-Paid Workers**	0	0	**Line 28**	(49,731)
30	**Donated Goods**	0	0	**Line 29**	(132,853)
31	**Amortization Expense**	0	0	**Line 30**	(81,441)
32	Independent Living Unit Wages - Maintenance	(10,000)	6	**Line 31**	0
33	Independent Living Unit Wages	(13,000)	10	**Line 32**	0
34	Independent Living Unit Wages - Administration	(15,000)	17	**Line 33**	0
35	Independent Living Unit Employee Benefits	(4,942)	22	**Line 34**	0
36	Independent Living Unit Wages	(17,774)	3	**Line 35**	0
37	Independent Living Unit Insurance	(1,795)	26	**Line 36**	0
38	Independent Living Unit Depreciation	(87,944)	30	**Line 37**	(81,441)
39	Independent Living Unit Promotion	(1,155)	7	**Line 38**	0
40	Independent Living Unit Utilities	(22,902)	5	**Line 39**	0
41	Independent Living Unit Supplies	(302)	21	**Line 40**	(19,187)
42	Independent Living Unit Maintenance & Other	(1,791)	6	**Line 41**	0
43	Independent Living Unit Food	(5,955)	2	**Line 42**	0
44	Administration Costs for Brother's Residence	(5,322)	17	**Line 43**	0
45	Adj Barber & Beauty Due to Income Received	(19,187)	40	**Line 44**	(19,187)
46	Adj Sundries Due to Income Received	(762)	15	**Line 45**	(233,481)
47					
48	Total	(207,831)			
49					
50					
51					
52					
53					
54					
55					
56					

entered.

stments

justments


Reference 1
Reference 2
Reference 3
Reference 4
Reference 5

Reference 6	Reference 7	Reference 9	Reference 10	Reference 10a	Reference 11	Reference 12	Reference 13	Reference 14	Reference 15

Reference 17 Reference 18 Reference 19 Reference 20 Reference 21 Reference 22 Reference 23 Reference 24 Reference 25 Reference 26

Reference 27	Reference 30	Reference 31	Reference 32	Reference 33	Reference 34	Reference 35	Reference 36	Reference 38	Reference 39

Reference 40 Reference 41 Reference 42 Reference 43

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number Arthur Merkle Clara Knipprath Nursing Home **#** 0021832 **Report Peri**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary A

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E
	A. General Services							
1	Dietary	0	0	0	0	0	0	0
2	Food Purchase	(12,250)	0	0	0	0	0	0
3	Housekeeping	(17,774)	0	0	0	0	0	0
4	Laundry	0	0	0	0	0	0	0
5	Heat and Other Utilities	(22,902)	0	0	0	0	0	0
6	Maintenance	(11,791)	0	0	0	0	0	0
7	Other (specify):*	(1,155)	0	0	0	0	0	0
8	**TOTAL General Services**	(65,872)	0	0	0	0	0	0
	B. Health Care and Programs							
9	Medical Director	0	0	0	0	0	0	0
10	Nursing and Medical Records	(13,000)	0	0	0	0	0	0
10a	Therapy	0	0	0	0	0	0	0
11	Activities	(3,488)	0	0	0	0	0	0
12	Social Services	0	0	0	0	0	0	0
13	Nurse Aide Training	0	0	0	0	0	0	0
14	Program Transportation	0	0	0	0	0	0	0
15	Other (specify):*	(762)	0	0	0	0	0	0
16	**TOTAL Health Care and Programs**	(17,250)	0	0	0	0	0	0
	C. General Administration							
17	Administrative	(20,322)	0	0	0	0	0	0
18	Directors Fees	0	0	0	0	0	0	0
19	Professional Services	0	0	0	0	0	0	0
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0
21	Clerical & General Office Expenses	(302)	0	0	0	0	0	0
22	Employee Benefits & Payroll Taxes	(4,942)	0	0	0	0	0	0
23	Inservice Training & Education	0	0	0	0	0	0	0
24	Travel and Seminar	0	0	0	0	0	0	0
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0
26	Insurance-Prop.Liab.Malpractice	(1,795)	0	0	0	0	0	0
27	Other (specify):*	(22,370)	0	0	0	0	0	0
28	**TOTAL General Administration**	(49,731)	0	0	0	0	0	0
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(132,853)	0	0	0	0	0	0

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

Summary A

od Beginning: 1/1/2000 Ending: 12/31/2000

PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
0	0	0	0	0	1
0	0	0	0	(12,250)	2
0	0	0	0	(17,774)	3
0	0	0	0	0	4
0	0	0	0	(22,902)	5
0	0	0	0	(11,791)	6
0	0	0	0	(1,155)	7
0	0	0	0	(65,872)	8
0	0	0	0	0	9
0	0	0	0	(13,000)	10
0	0	0	0	0	10a
0	0	0	0	(3,488)	11
0	0	0	0	0	12
0	0	0	0	0	13
0	0	0	0	0	14
0	0	0	0	(762)	15
0	0	0	0	(17,250)	16
0	0	0	0	(20,322)	17
0	0	0	0	0	18
0	0	0	0	0	19
0	0	0	0	0	20
0	0	0	0	(302)	21
0	0	0	0	(4,942)	22
0	0	0	0	0	23
0	0	0	0	0	24
0	0	0	0	0	25
0	0	0	0	(1,795)	26
0	0	0	0	(22,370)	27
0	0	0	0	(49,731)	28
0	0	0	0	(132,853)	29

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number Arthur Merkle Clara Knipprath Nursing Home **#** 0021832 **Report Per**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary B

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E
30	Depreciation	(81,441)	0	0	0	0	0	0
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0
32	Interest	0	0	0	0	0	0	0
33	Real Estate Taxes	0	0	0	0	0	0	0
34	Rent-Facility & Grounds	0	0	0	0	0	0	0
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0
36	Other (specify):*	0	0	0	0	0	0	0
37	**TOTAL Ownership**	(81,441)	0	0	0	0	0	0
	Ancillary Expense							
	E. Special Cost Centers							
38	Medically Necessary Transportation	0	0	0	0	0	0	0
39	Ancillary Service Centers	0	0	0	0	0	0	0
40	Barber and Beauty Shops	(19,187)	0	0	0	0	0	0
41	Coffee and Gift Shops	0	0	0	0	0	0	0
42	Provider Participation Fee	0	0	0	0	0	0	0
43	Other (specify):*	0	0	0	0	0	0	0
44	**TOTAL Special Cost Centers**	(19,187)	0	0	0	0	0	0
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(233,481)	0	0	0	0	0	0

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.

5. The amounts in the column Q are linked to page 4.

SEE ACCOUNTANTS' COMPILATION REPORT

Summary B

riod Beginning: 1/1/2000 Ending: 12/31/2000

PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
0	0	0	0	(81,441)	30
0	0	0	0	0	31
0	0	0	0	0	32
0	0	0	0	0	33
0	0	0	0	0	34
0	0	0	0	0	35
0	0	0	0	0	36
0	0	0	0	(81,441)	37
0	0	0	0	0	38
0	0	0	0	0	39
0	0	0	0	(19,187)	40
0	0	0	0	0	41
0	0	0	0	0	42
0	0	0	0	0	43
0	0	0	0	(19,187)	44
0	0	0	0	(233,481)	45

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number Arthur Merkle Clara Knipprath Nursing Home # 0021832

Show Pgs 6A thru 6D | Show Pgs 6E thru 6I | Hide Pgs 6A thru 6I

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions

1 OWNERS		2 RELATED NURSING HOMES	
Name	Ownership %	Name	City
Franciscan Missionary Brothers of the Sacred Heart of Jesus	100.0	N/A	

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [x] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization
1	V			$	
2	V				
3	V				
4	V				
5	V				
6	V				
7	V				
8	V				
9	V				
10	V				
11	V				
12	V				
13	V				

14	Total			$	

*** Total must agree with the amount recorded on line 34 of Schedule VI.** **SEE ACCOUNTANTS' COMPI**

Print Preview

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line numb
5. The adjustments entered on this page will automatically transfer to the summary pages.

Report Period Beginning: 1/1/2000 **Ending:** 12/31/2000

s. Attach an additional schedule if necessary.

	3 OTHER RELATED BUSINESS ENTITIES		
	Name	**City**	**Type of Business**

	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		$	$	1
				2
				3
				4
				5
				6
				7
				8
				9
				10
				11
				12
				13

Sum_6

	$	$ *	14

LATION REPORT

.

	Line 1	Line 2	Line 3	Line 4	Line 5
er 10a.					

Line 6	Line 7	Line 9	Line 10	Line 10a	Line 11	Line 12	Line 13	Line 14	Line 15

Line 17	Line 18	Line 19	Line 20	Line 21	Line 22	Line 23	Line 24	Line 25	Line 26

Line	Line	Line	Line	Line	Line	Line	Line	Line	Line
27	30	31	32	33	34	35	36	38	39

Line	Line	Line	Line
40	41	42	43

STATE OF ILLINOIS

Facility Name & ID Number Arthur Merkle Clara Knipprath Nursing Ho # 0021832 Report Perioc

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hou Week Dev Facility and Work Hours
1	Bro. Damien Dabraekeleer	Executive Director	Administrator	0.00	0	46
2	Bro. William Farrelly	Director	Nursing	0.00	0	44
3	Bro. Joseph Ruscha	Director	Maintenance	0.00	0	44
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nur of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE TI

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RE

ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE

SEE ACCOUNTANTS' COMPILATION REP

Print Preview

l Beginning: 1/1/2000 Ending: 12/31/2000

of compensation from this home

6 urs Per Work oted to this l % of Total Week	7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
Percent	Description	Amount		
100.00	Stipend to	$ 75,000	Col 4, Ln 17	1
100.00	religious	67,500	Col 4, Ln 10	2
100.00	order.	49,996	Col 4, Ln 6	3
				4
				5
				6
				7
				8
				9
				10
				11
				12
	TOTAL	$ 192,496		13

sing homes, attach a schedule detailing the name(s)
HE OTHER NURSING HOMES' COST REPORTS

report (i.e., management fees).
ECEIVED FROM THIS HOME,

OF SUCH COMPENSATION

ORT

Facility Name & ID Number Arthur Merkle Clara Knipprath Nursing Home # 0021832 Repor

VIII. ALLOCATION OF INDIRECT COSTS

Show Pgs 8A thru 8D | Show Pgs 8E thru 8I | Hide Pgs 8A thru 8I

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [x]

B. Show the allocation of costs below. If necessary, please attach worksheets.

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	
1						$
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
20						
21						
22						
23						
24						

25	TOTALS					$

SEE ACCOUNTANTS' C

Print Preview

't Period Beginning: 1/1/2000 Ending: 2/31/2000

thru 8I

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
	$		$	1
				2
				3
				4
				5
				6
				7
				8
				9
				10
				11
				12
				13
				14
				15
				16
				17
				18
				19
				20
				21
				22
				23
				24

	$		$	25

COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Arthur Merkle Clara Knipprath Nursing Hor # 0021832 Report Period Begi

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount o Original	
	A. Directly Facility Related							
	Long-Term							
1	None						$	$
2								
3								
4								
5								
	Working Capital							
6	None							
7								
8								
9	TOTAL Facility Related						$	$
	B. Non-Facility Related*							
10	None							
11								
12								
13								
14	TOTAL Non-Facility Related						$	$
15	TOTALS (line 9+line14)						$	$

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

SEE ACCOUNTANTS' COMPIL

Print Preview

inning: 1/1/2000 Ending: 12/31/2000

7	8	9	10	
f Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
			$	1
				2
				3
				4
				5
				6
				7
				8
			$	9
				10
				11
				12
				13
			$	14
			$	15

ATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Arthur Merkle Clara Knipprath Nursing Home **#** 0021832 **Repo**

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.

2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, deta

3. Under or (over) accrual (line 2 minus line 1).

4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)

5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Sche
(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed

6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.

TOTAL REFUND $ _____ **For 19** ____ **Tax Year.** **(Attach a copy of the real estate tax appeal b**

7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:					
	1995		**8**		
	1996		**9**		
	1997		**10**		**13**
	1998		**11**		
	1999		**12**		**14**
					15
					16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit e**

This denial must be no more than four years old at the time the cost repo

SEE ACCOUNTANTS' COMPILATION RE

Print Preview

rt Period Beginning: 1/1/2000 **Ending:** 12/31/2000

	$	Tax Exempt	1
ail below.)	$		2
	$		3
	$		4
edule V, sections A, B or C. with the county.)	$		5
 oard's decision.)	$		6
	$		7

FOR OHF USE ONLY		
FROM R. E. TAX STATEMENT FOR 1999	$	13
PLUS APPEAL COST FROM LINE 5	$	14
LESS REFUND FROM LINE 6	$	15
AMOUNT TO USE FOR RATE CALCULATION	$	16

ntity.

rt is filed.

PORT

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 53,919 B. General Construction Type: Exterior Brick Fra

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organiz

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nu List entity name, type of business, square footage, and number of beds/units available (where applicable).

Countryside Villas, 15 Independent Living Units - 17005 square feet

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over W

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-opera

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	
1	SNF	1,730,560	1975	$
2	Farm/Indep Living Units	995,072	1975	

3	TOTALS			2,725,632	$

SEE ACCOUNTANTS' COMPILATION R

Print Preview

rt Period Beginning: 1/1/2000 Ending: 12/31/2000

me Masonry Number of Stories 1

[ ] (c) Rent from Completely Unrelated Organization.

instructions.)

ation. [ ] (c) Rent equipment from Completely Unrelated Organization.

. See instructions.)

this nursing home's grounds
rse aide training facilities, etc.)

[ ] YES [x] NO

hich it is Being Amortized:

ıting costs.)

4	
Cost	
24,225	1
32,775	2

	57,000	3

EPORT

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Show Pgs 12A & 12B

Show Pgs 12C and 12D

STATE OF ILLINOIS

Facility Name & ID Number Arthur Merkle Clara Knipprath Nursing Home # 0021832 Report Perio

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years
4	99		1975	1975	$ 773,471	$ 18,194	33
5			1975	1975	432,948	8,653	25
6							
7							
8							
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3						
9	Fixed Equipment			1981	924	0	5
10				1982	656	0	15
11				1983	5,462	253	17
12				1984	16,618	587	15
13				1985	6,098	235	15
14				1986	2,400	0	10
15				1987	6,773		25
16				1988	650	45	15
17				1979	2,032		5
18				1980	14,012		15
19				1989	9,327	387	20
20				1990	1,276	63	10
21				1991	25,219	1,291	20
22				1992	6,594	440	15
23				1993	2,825	282	10
24				1994	581	58	10
25				1995	97,366	4,109	25
26	Kitchen Fire Supression System			1996	2,115	106	20
27	Nurses Station Improvement			1996	5,395	360	15
28	Vertical Blinds - Arthur Wing			1996	350	35	10
29	Heat Pump Compressor			1996	1,890	189	10
30	Therapy Room Cubicle			1996	321	32	10
31	Kitchen Heat Pump			1996	1,679	168	10
32	Water Heaters			1996	4,158	277	15
33	Call light System Improvements			1996	1,348	90	15
34	Room Heaters			1996	3,603	360	10
35	Pump Improvement			1997	2,540	508	5
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$ 36,722	

*Total beds on this schedule must agree with page 2.

SEE ACCOUNTANTS' COMPILATION REPORT

****Improvement type must be detailed in order for the cost report to be considered complete.**

Print Preview

:D

Hide Pgs 12A thru 12D

d Beginning: 1/1/2000 Ending: 12/31/2000

7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
$ 18,194	$	$ 558,969	4
8,653		364,279	5
			6
			7
			8
0		924	9
0		656	10
253		4,610	11
587		14,562	12
239	4	4,189	13
		2,400	14
		6,773	15
47	2	538	16
		2,032	17
		14,012	18
387		5,220	19
63		1,276	20
1,291		12,263	21
440		3,740	22
282		2,119	23
58		377	24
4,109		22,600	25
106		476	26
360		1,619	27
35		157	28
189		851	29
32		144	30
168		756	31
277		1,247	32
90		405	33
360		1,620	34
508		1,778	35
$ 36,728	$ 6	$ 1,030,592	36

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Pag

STATE OF ILLINOIS

Facility Name & ID Number Arthur Merkle Clara Knipprath Nursing Home # 0021832 Report Perio

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years
4					$	$	
5							
6							
7							
8							
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3						
9	Fire Alarm Improvement			1997	1,105	221	5
10	Fire Safety Code Improvement			1997	5,844	390	15
11	Procare Nurse Call System			1997	36,033	2,403	15
12	Garbage Disposal			1998	1,142	76	15
13	Heat Pump			1998	2,853	285	10
14	Fire Door			1998	200	10	20
15	Room Heat/Cool			1998	3,632	363	10
16	Generator			1998	141,059	7,052	20
17	Cubicle Curtains			1998	5,250	525	10
18	Register Covers			1999	1,056	106	10
19	Walk-in Freezer/Cooler			1999	20,126	805	25
20	Water Heater Booster			1999	1,131	113	10
21	Above Ground Tank			1999	1,495	149	10
22	Air/Heat Unit			1999	1,057	211	5
23	Air Return Extension			2000	1,532	51	15
24	Stainless Garbage Disposal			2000	527	13	20
25	2 Air/Heat Units			2000	1,950	195	5
26							
27	Land Improvements			1975	194,467	2,899	25
28				1979	8,614	2	20
29				1982	42,700	337	11
30				1983	1,999	100	20
31				1984	3,405	170	20
32				1985	860		12
33				1986	6,156	425	15
34				1980	762	0	20
35				1992	6,346	317	20
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$ 17,218	

***Total beds on this schedule must agree with page 2.** **SEE ACCOUNTANTS' COMPILATION REP(**

****Improvement type must be detailed in order for the cost report to be considered complete.**

Print Preview

d Beginning: 1/1/2000 Ending: 12/31/2000

7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
$	$	$	4
			5
			6
			7
			8
221		773	9
390		1,364	10
2,403		8,408	11
76		190	12
285		713	13
10		25	14
363		908	15
7,052		17,632	16
525		1,313	17
100	(6)	158	18
805		1,208	19
113		170	20
149		224	21
211		317	22
51		51	23
13		13	24
195		195	25
0			26
2,899		152,425	27
2		8,614	28
337		42,054	29
100		1,749	30
170		2,808	31
0		860	32
425		5,943	33
16	16	762	34
317		2,696	35
$ 17,228	$ 10	$ 251,573	36

ORT

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Pag

STATE OF ILLINOIS

Facility Name & ID Number Arthur Merkle Clara Knipprath Nursing Home # 0021832 Report Per

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years
4					$	$	
5							
6							
7							
8							
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3						
9	Land Improvement			1993	3,640		5
10				1995	6,753	413	15
11	Driveway Pavement			1997	8,900	593	15
12	Well			1998	7,339	367	20
13	Sewer Improvement			1999	13,399	1,340	10
14	Driveway Sealing			2000	8,945	895	5
15	Building - Interior Corridor Doors			2000	2,415	81	10
16	Buildings			1980	4,422	111	20
17				1981	1,738	0	10
18				1982	1,106	44	25
19				1984	130,023	19	20
20				1985	598	20	15
21				1986	640,838	20,956	33
22				1987	37,528	2,502	15
23				1988	13,228	882	15
24				1989	10,488	100	15
25				1990	2,096	104	10
26				1991	35,542	1,815	20
27				1992	(34,187)	(810)	40
28				1993	475	48	10
29	Floor Tile Nurse Stat/Entry			1996	2,050	137	15
30	Floor Tile Clara Wing			1996	778	52	15
31	Floor Tile Main, Kitchen			1997	14,739	2,106	7
32	Hallway Improv			1997	3,870	774	5
33	Roof Improvements			1997	13,828	922	15
34	Floor Tile Arthur Wing			1998	6,475	647	10
35	DR Floor Tile			1999	4,420	884	5
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$ 35,002	

***Total beds on this schedule must agree with page 2.** **SEE ACCOUNTANTS' COMPILATION REI**

****Improvement type must be detailed in order for the cost report to be considered complete.**

Print Preview

iod Beginning: 1/1/2000 Ending: 12/31/2000

	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
	$	$	$	4
				5
				6
				7
				8
			3,640	9
	413		2,270	10
	593		2,076	11
	367		917	12
	1,340		2,010	13
	895		895	14
	81		81	15
	111		4,422	16
	0		1,738	17
	44		818	18
	6,500	6,481	104,026	19
	20		598	20
	20,956		306,415	21
	2,502		33,687	22
	882		11,023	23
	100		10,141	24
	104		2,096	25
	1,815		17,242	26
	(810)		(6,885)	27
	48		358	28
	137		615	29
	52		234	30
	2,106		7,370	31
	774		2,709	32
	922		3,227	33
	647		1,618	34
	884		1,326	35
	$ 41,483	$ 6,481	$ 514,667	36

PORT

STATE OF ILLINOIS

Facility Name & ID Number Arthur Merkle Clara Knipprath Nursing Home # 0021832 Report Period Be

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Stra Dep
37	Purchased in Prior Years	$ 216,761	$ 18,333	$
38	Current Year Purchases	19,385	1,066	
39	Fully Depreciated Assets	173,015	0	
40				
41	TOTALS	$ 409,161	$ 19,399	$

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Stra Dep
42	Pick-up Truck	75 Chevy	1975	$ 5,679	$ 0	$
43	Patient Transport	96 Ford Eldorado Transit Bus	1996	38,099	3,810	
44	Facility Business	96 Mercury Sable	1996	15,878	1,986	
45	Patient Transport	93 Mercury Villager Van	1992	18,387	0	
46	TOTALS			$ 78,043	$ 5,796	$

E. Summary of Care-Related Assets

		1 Reference
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4		
52	Brothers' Residence	$ 94,816	$ 2,370	$ 60,444	52	58
53	Brothers' Residence Equipment	18,552	728	10,514	53	59
54	Apartment Comlpex Bldg	1,754,639	53,491	451,358	54	60
55	Apartment Comlpex Equipment	719,136	33,381	299,281	55	61
56	Apartment Comlpex Land Impr	21,325	1,066	9,596	56	

57	**TOTALS**	**$**	**2,608,468**	**$**	**91,036**	**$**	**831,193**	**57**

*

SEE ACCOUNTANTS' COMPILATION REPORT **

Print Preview

eginning: 1/1/2000 Ending: 12/31/2000

ight Line reciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
18,333	$	Various	$ 67,089	37
1,066		Various	1,066	38
		Various	173,015	39
				40
19,399	$		$ 241,170	41

ight Line reciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
0	$	5	$ 5,679	42
3,810		10	17,145	43
1,986		4	15,878	44
0		5	18,387	45
5,796	$		$ 57,089	46

	2 Amount		
	$	#VALUE!	47
	$	114,137	48
	$	120,634	49 **
	$	6,497	50
	$	2,095,091	51

G. Construction-in-Progress

Description	Cost	
	$	58
		59
		60
	$	61

Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

This must agree with Schedule V line 30, column 8.

STATE OF ILLINOIS

Facility Name & ID Number Arthur Merkle Clara Knipprath Nursing Home # 0021832

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Y Renewal C
3	Original Building:				$		
4	Additions						
5							
6							
7	TOTAL				$ **		

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing th

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

Print Preview

Report Period Beginning: 1/1/2000 **Ending:** 12/31/2000

'ears)ption*	
	3
	4
	5
	6
	7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

ıe breakdown of movable equipment)

*** If there is an option to buy the building, please provide complete details on attached schedule.**

**** <u>This amount plus any amortization of lease expense must agree with page 4, line 34.</u>**

STATE OF ILLINOIS

Facility Name & ID Number Arthur Merkle Clara Knipprath Nursing Home #

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [x] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM [ ]

IN OTHER FACILITY [ ]

COMMUNITY COLLEGE [ ]

HOURS PER AIDE ____

A requirement for new nurses aids is that they have already completed the proper training.

B. EXPENSES

ALLOCATION OF COSTS (d)

			1	2	3	
			Facility			
			Drop-outs	Completed	Contract	
1	Community College Tuition		$	$	$	$
2	Books and Supplies					
3	Classroom Wages	(a)				
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS		$	$	$	$
10	SUM OF line 9, col. 1 and 2	(e)	$			

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides. **SEE**

Print Preview

y name, address and cost per aide trained in that facility.)

3. CLINICAL PORTION:

IN-HOUSE PROGRAM ☐

IN OTHER FACILITY ☐

HOURS PER AIDE ____

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

4

Total $

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses

of those facilities for which you trained aides.

ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2		3	4	
	Service	Schedule V Line & Column Reference	Staff			Outside Pra (other than c	
			Units of Service		Cost	Units	
1	Licensed Occupational Therapist		hrs		$		$
2	Licensed Speech and Language Development Therapist		hrs				
3	Licensed Recreational Therapist		hrs				
4	Licensed Physical Therapist		hrs				
5	Physician Care		visits				
6	Dental Care		visits				
7	Work Related Program		hrs				
8	Habilitation		hrs				
9	Pharmacy		# of prescrpts				
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs				
11	Academic Education		hrs				
12	Exceptional Care Program						
13	Other (specify):						
14	TOTAL				$		$

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be deta Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not b on this schedule.

Print Preview

SEE ACCOUNTANTS' COMPIL

ort Period Beginning: 1/1/2000 Ending: 12/31/2000

5	6	7	8	
actitioner onsultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
	$		$	1
				2
				3
				4
				5
				6
				7
				8
				9
				10
				11
				12
				13
	$		$	14

iled on
e listed

.ATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Arthur Merkle Clara Knipprath Nursing Home # 0021832

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2000

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*		
	A. Current Assets				
1	Cash on Hand and in Banks	$ 18,871	$	1	26
2	Cash-Patient Deposits			2	27
	Accounts & Short-Term Notes Receivable-				28
3	Patients (less allowance 18,000)	244,197		3	29
4	Supply Inventory (priced at)			4	30
5	Short-Term Investments	2,415,876		5	
6	Prepaid Insurance	16,316		6	31
7	Other Prepaid Expenses			7	32
8	Accounts Receivable (owners or related parties)			8	33
9	Other(specify): Accrued Int & Grain on Hand	25,256		9	34
	TOTAL Current Assets				35
10	**(sum of lines 1 thru 9)**	$ 2,720,516	$	10	
	B. Long-Term Assets				36
11	Long-Term Notes Receivable			11	37
12	Long-Term Investments	158,236		12	
13	Land	388,847		13	38
14	Buildings, at Historical Cost	3,515,396		14	
15	Leasehold Improvements, at Historical Cost			15	39
16	Equipment, at Historical Cost	2,104,348		16	40
17	Accumulated Depreciation (book methods)	(2,948,562)		17	41
18	Deferred Charges			18	42
19	Organization & Pre-Operating Costs			19	
	Accumulated Amortization -				43
20	Organization & Pre-Operating Costs			20	44
21	Restricted Funds			21	
22	Other Long-Term Assets (specify):			22	45
23	Other(specify):			23	
	TOTAL Long-Term Assets				46
24	**(sum of lines 11 thru 23)**	$ 3,218,265	$	24	
					47
	TOTAL ASSETS				
25	**(sum of lines 10 and 24)**	$ 5,938,781	$	25	48

SEE ACCOUNTANTS' COMPILATION REPORT ***(See instructions.)**

Print Preview

Report Period Beginning: 1/1/2000 **Ending:** 12/31/2000
(last day of reporting year)

	1 Operating	2 After Consolidation*	
C. Current Liabilities			
Accounts Payable	$ 47,357	$	26
Officer's Accounts Payable			27
Accounts Payable-Patient Deposits			28
Short-Term Notes Payable			29
Accrued Salaries Payable	35,674		30
Accrued Taxes Payable (excluding real estate taxes)	13,189		31
Accrued Real Estate Taxes(Sch.IX-B)			32
Accrued Interest Payable			33
Deferred Compensation			34
Federal and State Income Taxes			35
Other Current Liabilities(specify):			
Apartment Rental Deposits	12,660		36
			37
TOTAL Current Liabilities (sum of lines 26 thru 37)	$ 108,880	$	38
D. Long-Term Liabilities			
Long-Term Notes Payable			39
Mortgage Payable			40
Bonds Payable			41
Deferred Compensation			42
Other Long-Term Liabilities(specify):			
			43
			44
TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	$	$	45
TOTAL LIABILITIES (sum of lines 38 and 45)	$ 108,880	$	46
TOTAL EQUITY(page 18, line 24)	$ 5,829,901	$	47
TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	$ 5,938,781	$	48

Facility Name & ID Number **Arthur Merkle Clara Knipprath Nursing Home** **#** **0021832** **Repo**

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 5,451,153	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 5,451,153	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	578,748	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 578,748	17
	B. Transfers (Itemize):		
18	**Transfer to Sponsoring Organization**	(200,000)	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (200,000)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 5,829,901	24

*** This must agree with p**

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

ort Period Beginning: 1/1/2000 Ending: 12/31/2000

*****

page 17, line 47.

STATE OF ILLINOIS

Facility Name & ID Number Arthur Merkle Clara Knipprath Nursing Home # 0021832 **Report Period Beginning:**

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All re classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,412,935	1
2	Discounts and Allowances for all Levels	(764,823)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,648,112	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	9,308	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 9,308	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	32,597	13
14	Non-Patient Meals	16,137	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 48,734	23
	D. Non-Operating Revenue		
24	Contributions	126,255	24
25	Interest and Other Investment Income***	124,740	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 250,995	26
	E. Other Revenue (specify):****		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**Rental & Farm**	213,714	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 213,714	29

	Expenses
	A. Operating Expenses
31	General Services
32	Health Care
33	General Administration
	B. Capital Expense
34	Ownership
	C. Ancillary Expense
35	Special Cost Centers
36	Provider Participation Fee
	D. Other Expenses (specify):
37	
38	
39	
40	**TOTAL EXPENSES (sum of l**
41	**Income before Income Taxes (**
42	**Income Taxes**
43	**NET INCOME OR LOSS FOR**

* **This must agree with page 4, li**

** **Does this agree with taxable in Tax Return?**

*** **See the instructions. If this tota against interest expense on Sch detailed explanation.**

30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	**$**	**3,170,863**	**30**

******Provide a detailed breakdown o**

Print Preview

1/1/2000 Ending: 12/31/2000

quired

	2 Amount	
	$ 753,759	31
	1,023,628	32
	536,016	33
	205,173	34
	19,187	35
	54,352	36
		37
		38
		39
ines 31 thru 39)*	$ 2,592,115	40
line 30 minus line 40)**	578,748	41
		42
R THE YEAR (line 41 minus line 42)	$ 578,748	43

ne 45, column 4.

come (loss) per Federal Income
If not, please attach a reconciliation.

al amount has not been offset
nedule V, line 32, please include a

of "Other Revenue" on an attached sheet.

Facility Name & ID Number Arthur Merkle Clara Knipprath Nursing Home # 0021832

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

B. C(

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage		
1	Director of Nursing	1,713	1,945	$ 44,151	$ 22.70	1	
2	Assistant Director of Nursing					2	35
3	Registered Nurses	7,515	8,259	169,404	20.51	3	36
4	Licensed Practical Nurses	12,724	13,796	194,160	14.07	4	37
5	Nurse Aides & Orderlies	45,426	49,486	423,182	8.55	5	38
6	Nurse Aide Trainees					6	39
7	Licensed Therapist					7	40
8	Rehab/Therapy Aides	1,560	1,752	15,377	8.78	8	41
9	Activity Director	1,724	1,932	19,459	10.07	9	42
10	Activity Assistants	3,443	3,843	32,459	8.45	10	43
11	Social Service Workers	1,139	1,219	11,074	9.08	11	44
12	Dietician					12	45
13	Food Service Supervisor	1,741	1,981	32,070	16.19	13	46
14	Head Cook					14	47
15	Cook Helpers/Assistants	22,689	24,609	204,231	8.30	15	48
16	Dishwashers					16	
17	Maintenance Workers	3,961	4,185	69,571	16.62	17	49
18	Housekeepers	6,855	7,495	62,746	8.37	18	
19	Laundry	3,569	3,841	31,202	8.12	19	
20	Administrator	2,400	2,496	77,444	31.03	20	
21	Assistant Administrator					21	
22	Other Administrative					22	
23	Office Manager					23	
24	Clerical	5,600	5,960	62,316	10.46	24	
25	Vocational Instruction					25	
26	Academic Instruction					26	
27	Medical Director					27	50
28	Qualified MR Prof. (QMRP)					28	51
29	Resident Services Coordinator					29	52
30	Habilitation Aides (DD Homes)					30	
31	Medical Records	2,288	2,528	19,766	7.82	31	53
32	Other Health Care(specify)					32	

C. C(

33	Other(specify)					33
34	TOTAL (lines 1 - 33)	124,347	135,327	$ 1,468,612 *	$ 10.85	34

*** This total must agree with page 4, column 1, line 45.** **** See instructions.** **SEE ACC**

Print Preview

0

Report Period Beginning: 1/1/2000 Ending: 12/31/2000

ONSULTANT SERVICES

	1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
Dietary Consultant	127	$ 5,380	Ln 1 Col 3	35
Medical Director	36	2,400	Ln 9 Col 3	36
Medical Records Consultant				37
Nurse Consultant				38
Pharmacist Consultant	36	600	Ln 10 Col 3	39
Physical Therapy Consultant	22	1,118	Ln10a Col 3	40
Occupational Therapy Consultant				41
Respiratory Therapy Consultant				42
Speech Therapy Consultant				43
Activity Consultant				44
Social Service Consultant				45
Other(specify)				46
				47
				48
TOTAL (lines 35 - 48)	221	$ 9,498		49

ONTRACT NURSES

	1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
Registered Nurses		$		50
Licensed Practical Nurses				51
Nurse Aides				52
TOTAL (lines 50 - 52)		$		53

OUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Arthur Merkle Clara Knipprath Nursing Home # 0021832 Rep

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Brother Damien	Administrator	0.00%	$ 75,000
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 75,000

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
Bacon Smith Koelling & Ohm	Accounting & Audit	$ 14,450
American Appraisal	Asset Recordkeeping	1,305
Premier Data	Payroll Service	2,365
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 18,120

D. Employee Benefits and Payroll Taxes

Description	
Workers' Compensation Insurance	$
Unemployment Compensation Insurance	
FICA Taxes	
Employee Health Insurance	
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Retirement Plan Contribution	
TOTAL (agree to Schedule V, line 22, col.8)	$

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	
		$
TOTAL		$

*** Attach copy of IMRF notifications**
SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

ort Period Beginning: 1/1/2000 Ending: 12/31/2000

Amount	F. Dues, Fees, Subscriptions and Promotions Description		Amount
33,941	IDPH License Fee	$	152
	Advertising: Employee Recruitment		
107,066	Health Care Worker Background Check		84
123,624	(Indicate # of checks performed 7)		
20,480	Life Services Network Membership		3,493
	NARB Membership		35
35,821	Division of Aging		50
	Catholic Health Assoc		100
	The Daily Journal/The Advocate		163
	Sam's Club		45
	Less: Public Relations Expense	(	)
	Non-allowable advertising	(	)
	Yellow page advertising	(	)
320,932	TOTAL (agree to Sch. V, line 20, col. 8)	$	4,122

Amount	G. Schedule of Travel and Seminar** Description		Amount
	Out-of-State Travel	$	
	In-State Travel		
	Seminar Expense		
	Conference of Aging		70
	Ill Health Care Assoc Seminar		150
	Entertainment Expense	(	)
	TOTAL (agree to Sch. V, line 24, col. 8)	$	220

**See instructions.

STATE OF ILLINOIS

Facility Name & ID Number Arthur Merkle Clara Knipprath Nursing Home # 0021832 Repo

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount c			
					FY1997	FY1998	FY1999	FY2000
1			$		$	$	$	$
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20	TOTALS		$		$	$	$	$

SEE ACCOUNTANTS' COMPILATION

Print Preview

ort Period Beginning: **1/1/2000** **Ending:** **12/31/2000**

	9	10	11	12	13
of Expense Amortized Per Year					
	FY2001	FY2002	FY2003	FY2004	FY2005
	$	$	$	$	$
	$	$	$	$	$

REPORT

STATE OF ILLINOIS

Facility Name & ID Number **Arthur Merkle Clara Knipprath Nursing Home** **#** **0021832** **Repo**

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Life Services Network, $3,493.22**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **18.25**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **26,969** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **x** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **54,352**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and
the Department of Public Aid,
in the Ancillary Section of Sch

(14) Is a portion of the building use
the patient census listed on pag
is a portion of the building use
a schedule which explains how

(15) Indicate the cost of employee r
on Schedule V. $
related costs?

(16) Travel and Transportation
a. Are there costs included for
If YES, attach a complete ex
b. Do you have a separate cont
residents? **No** If Y
program during this reportin
c. What percent of all travel ex
d. Have vehicle usage logs bee
e. Are all vehicles stored at the
times when not in use?
f. Has the cost for commuting
out of the cost report?
g. Does the facility transpo
Indicate the amount of i
transportation during th

(17) Has an audit been performed b
Firm Name: **Bacon Smith**
cost report require that a copy
been attached? **Yes**

(18) Have all costs which do not rel
out of Schedule V? **Yes**

(19) If total legal fees are in excess
performed been attached to thi
Attach invoices and a summary

rt Period Beginning: 1/1/2000 Ending: 12/31/2000

services which are of the type that can be billed to
in addition to the daily rate, been properly classified
edule V? **Yes**

d for any function other than long term care services for
ge 2, Section B? **Yes** For example,
d for rental, a pharmacy, day care, etc.) If YES, attach
all related costs were allocated to these functions.

neals that has been reclassified to employee benefits
20,480 Has any meal income been offset against
Yes Indicate the amount. $ **16,137**

out-of-state travel? **No**
xplanation.
ract with the Department to provide medical transportation for
YES, please indicate the amount of income earned from such a
g period. $
pense relates to transportation of nurses and patients? **68%**
n maintained? **Yes**
nursing home during the night and all other
Yes
or other personal use of autos been adjusted
N/A
rt residents to and from day training? **No**
ncome earned from providing such
is reporting period. $

y an independent certified public accounting firm? **Yes**
Koelling & Ohm, PC The instructions for the
of this audit be included with the cost report. Has this copy
If no, please explain.

late to the provision of long term care been adjusted out

of $2500, have legal invoices and a summary of services
s cost report? **N/A**
y of services for all architect and appraisal fees.

0

STATE OF ILLINOIS

Facility Name & ID Number Arthur Merkle Clara Knipprath Nursing Home #21832

Diagnostic Report

				DIFFERENCE
Salary/Wages	Page 4, Line 45, Col 1		1468612	
	Page 20, Line 32, Col 3		1468612	0
Book Depreciation	Page 4, Line 30, Col 4		205173	
Care Related Depr	Page 13, Line 48	114137		
Non-Care Depr	PAGE 13, LINE 57, COL 3	91036	205173	0
Adjusted Depr	PAGE 4, LINE 30, COL 8		120634	
	PAGE 13, LINE 49		120634	0
Interest	PAGE 4, LINE 32, COL 6			
	PAGE 9, LINE 15, COL 10			0
	ADJ PAGE 5, LINE 10	0	0	
Adjustements	PAGE 4, LINE 45, COL 7		-233481	
	PAGE 5, LINE 30, COL 1		-233481	0
Administrative Salaries	PAGE 3, LINE 17, COL 4		75000	
	PAGE 7, LINE 1, COL 7		75000	0
	PAGE 21, SCHED A		75000	
PROFESSIONAL SERV	PAGE 3, LINE 19, COL 3		18120	
	PAGE 21, SCHED C		18120	0
DUES & SUBCRIPTION	PAGE 3, LINE 20, COL 8		4122	
	PAGE 21, SCHED F		4122	0
EMPLOYEE BENEFITS	PAGE 3, LINE 22, COL 8		320932	
	PAGE 21, SCHED D		320932	0

TRAVEL & SEMINAR	PAGE 3, LINE 24, COL 8		220		
	PAGE 21, SCHED G		220		0
DEPRECIATION-COST	PAGE 13, SCHED E, LINE 47		#VALUE!		
	PAGE 11, SCHED A, LINE 3	57000			
	PAGE 12, LINE 36, COL 4	#VALUE!			
	PAGE 13, LINE 41, COL 1	409161			
	PAGE 13, LINE 46, COL 4	78043	#VALUE!	#VALUE!	
DEPREC - CURRENT B	PAGE 13, SCHED E, LINE 48		114137		
	PAGE 12, LINE 36, COL 5	88942			
	PAGE 13, LINE 41, COL 2	19399			
	PAGE 13, LINE 46, COL 5	5796	114137		0
DEPREC - STRAIGHT L	PAGE 13, SCHED E, LINE 49		120634		
	PAGE 12, LINE 36, COL 7	95439			
	PAGE 13, LINE 41, COL 3	19399			
	PAGE 13, LINE 46, COL 6	5796	120634		0
DEPREC - ADJUSTMEI	PAGE 13, SCHED E, LINE 50		6497		
	PAGE 12, LINE 36, COL 8	6497			
	PAGE 13, LINE 41, COL 4				
	PAGE 13, LINE 46, COL 7		6497		0
ACCUMULATED DEPR	PAGE 13, SCHED E, LINE 51		2095091		
	PAGE 12, LINE 36, COL 9	1796832			
	PAGE 13, LINE 41, COL 6	241170			
	PAGE 13, LINE 46, COL 9	57089	2095091		0
BALANCE SHEET	TOTAL ASSETS-PAGE 17, LINE 25		5938781		
	TOTAL LIAB-PAGE 17, LINE 48		5938781		0
EQUITY	TOTAL EQUITY, PAGE 17, LINE 47		5829901		
	ENDING EQUITY, PAGE 18, LINE 24		5829901		0